



Network Platinum^{Plus} (PPO) offered by Network Health Insurance Corporation

Annual Notice of Changes for 2019

You are currently enrolled as a member of Network Platinum^{Plus}. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**
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What to do now

1. ASK: Which changes apply to you

- ☐ Check the changes to our benefits and costs to see if they affect you.
 - It's important to review your coverage now to make sure it will meet your needs next year.
 - Do the changes affect the services you use?
 - Look in Sections 1.1 and 1.4 for information about benefit and cost changes for our plan.
- ☐ Check to see if your doctors and other providers will be in our network next year.
 - Are your doctors in our network?
 - What about the hospitals or other providers you use?
 - Look in Section 1.3 for information about our Provider Directory.
- ☐ Think about your overall health care costs.
 - How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
 - How much will you spend on your premium and deductibles?
 - How do your total plan costs compare to other Medicare coverage options?
- ☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at <https://www.medicare.gov> website. Click “Find health & drug plans.”
- Review the list in the back of your Medicare & You handbook.
- Look in Section 3.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan’s website.

3. **CHOOSE: Decide whether** you want to change your plan

- If you want to **keep** Network Platinum*Plus*, you don’t need to do anything. You will stay in Network Platinum*Plus*.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2018**

- If you **don’t join another plan by December 7, 2018**, you will stay in Network Platinum*Plus*.
- If you join another plan by December 7, 2018, your new coverage will start on January 1, 2019.

Additional Resources

- Customer service has free language interpreter services available for non-English speakers (phone numbers are in Section 7.1 of this booklet).
- This information is available for free in other formats. For more information, please contact customer service at 800-378-5234, Monday through Friday, 8 a.m. to 8 p.m. TTY users should call 800-947-3529. From October 1, 2018 through March 31, 2019, we are available every day from 8 a.m. to 8 p.m.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at <https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families> for more information.

About Network Platinum*Plus*

- Network Health Medicare Advantage Plans include PPO, MSA and HMO plans with a Medicare contract. Enrollment in Network Health Medicare Advantage Plans depends on contract renewal.
 - When this booklet says “we,” “us,” or “our,” it means Network Health Insurance Corporation. When it says “plan” or “our plan,” it means Network Platinum*Plus*.
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Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for Network PlatinumPlus in several important areas. **Please note this is only a summary of changes. It is important to read the rest of this *Annual Notice of Changes*** and review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2018 (this year)	2019 (next year)
Monthly plan premium (See Section 1.1 for details.)	\$89	\$89
Maximum out-of-pocket amounts This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: \$3400 From in-network and out-of-network providers combined: \$3400	From network providers: \$3400 From in-network and out-of-network providers combined: \$3400
Doctor office visits	In-Network Primary care visits: \$10 per visit Specialist visits: \$40 per visit Out-of-Network Primary care visits: \$10 per visit Specialist visits: \$40 per visit.	In-Network Primary care visits: \$15 per visit Specialist visits: \$40 per visit Out-of-Network Primary care visits: \$15 per visit Specialist visits: \$40 per visit.

Cost	2018 (this year)	2019 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	In-Network \$375 copay per day for days 1-4 for a Medicare covered stay in a hospital. \$0 copay for all other days of a Medicare covered stay in a hospital. Additional days covered. Out-of-Network \$375 copay per day for days 1-4 for a Medicare covered stay in a hospital. \$0 copay for all other days of a Medicare covered stay in a hospital. Additional days covered.	In-Network \$375 copay per day for days 1-5 for a Medicare covered stay in a hospital. \$0 copay for all other days of a Medicare covered stay in a hospital. Additional days covered. Out-of-Network \$375 copay per day for days 1-5 for a Medicare covered stay in a hospital. \$0 copay for all other days of a Medicare covered stay in a hospital. Additional days covered.

Annual Notice of Changes for 2019

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	\$89	No change

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts

To protect you, Medicare requires all health plans to limit how much you pay “out-of-pocket” during the year. These limits are called the “maximum out-of-pocket amounts.” Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2018 (this year)	2019 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	\$3400 Once you have paid \$3400 out-of-pocket for covered Part A and Part B services from network providers, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.	No change
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	\$3400 Once you have paid \$3400 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.	No change

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at networkhealth.com. You may also call customer service for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2019 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2019 Evidence of Coverage*.

Cost	2018 (this year)	2019 (next year)
Chiropractic Services	In-Network You pay a \$15 copay for each Medicare covered chiropractic service. Out-of-Network You pay a \$15 copay for each Medicare covered chiropractic service.	In-Network You pay a \$20 copay for each Medicare covered chiropractic service. Out-of-Network You pay a \$20 copay for each Medicare covered chiropractic service.
Diabetic services and supplies	In-Network \$10 copay for Accu-Chek or OneTouch blood glucose test strips, diabetic therapeutic shoes or inserts, and each covered diabetic supply item up to a 90-day supply. Out-of-Network \$10 copay for Accu-Chek or OneTouch blood glucose test strips, diabetic therapeutic shoes or inserts, and each covered diabetic supply item up to a 90-day supply.	In-Network <i>\$0 copay for Accu-Chek or OneTouch blood glucose test strips and each covered diabetic supply item up to a 90-day supply.</i> \$10 copay for Medicare covered diabetic therapeutic shoes or inserts. Out-of-Network <i>\$0 copay for Accu-Chek or OneTouch blood glucose test strips and each covered diabetic supply item up to a 90-day supply.</i> \$10 copay for each Medicare covered diabetic shoes or inserts.

Cost	2018 (this year)	2019 (next year)
Emergency Care	In-Network You pay a \$100 copay for each Medicare covered emergency care visit. Out-of-Network You pay a \$100 copay for each Medicare covered emergency care visit.	In-Network You pay a \$120 copay for each Medicare covered emergency care visit. Out-of-Network You pay a \$120 copay for each Medicare covered emergency care visit.
Hearing Aids	As a supplemental benefit, you have access to the following hearing aids at the prices listed below when you see a participating provider: • Cros Pure Signia and Cros Widex: \$1000 each hearing aid • 2nd Generation Midlevel: \$1220 each hearing aid • 2nd Generation High Level: \$1420 each hearing aid • 2nd Generation Premium: \$1620 each hearing aid • 1st Generation Midlevel: \$1565 each hearing aid • 1st Generation High Level: \$1765 each hearing aid • 1st Generation Premium: \$1985 each hearing aid Hearing aids are available from four (4) manufacturers: Widex, Siemens, Oticon and Starkey	As a supplemental benefit, you have access to the following hearing aids at the prices listed below when you see a participating provider: • 2nd Generation Midlevel: \$1220 each hearing aid • 2nd Generation High Level: \$1420 each hearing aid • 2nd Generation Premium: \$1620 each hearing aid • 1st Generation Midlevel: \$1565 each hearing aid • 1st Generation High Level: \$1765 each hearing aid • 1st Generation Premium: \$1985 each hearing aid Hearing aids are available from four (4) manufacturers: Widex, Siemens, Oticon and Starkey

Cost	2018 (this year)	2019 (next year)
Inpatient Hospital-Acute	In-Network You pay a \$375 copay per day for days 1-4 for a Medicare covered stay in a hospital. You pay a \$0 copay per day for all other days of a Medicare covered stay in a hospital. Additional days are covered. Out-of-Network You pay a \$375 copay per day for days 1-4 of a Medicare covered stay in a hospital. You pay a \$0 copay per day for all other days of a Medicare covered stay in a hospital. Additional days are covered.	In-Network You pay a \$375 copay per day for days 1-5 for a Medicare covered stay in a hospital. You pay a \$0 copay per day for all other days of a Medicare covered stay in a hospital. Additional days are covered. Out-of-Network You pay a \$375 copay per day for days 1-5 of a Medicare covered stay in a hospital. You pay a \$0 copay per day for all other days of a Medicare covered stay in a hospital. Additional days are covered.
Primary Care Physician Service	In-Network You pay a \$10 copay for each Medicare covered PCP visit. Out-of-Network You pay a \$10 copay for each Medicare covered PCP visit.	In-Network You pay a \$15 copay for each Medicare covered PCP visit. Out-of-Network You pay a \$15 copay for each Medicare covered PCP visit.

Cost	2018 (this year)	2019 (next year)
Outpatient diagnostic tests	In-Network \$5 copay for each Medicare covered diagnostic procedure, test and/or lab service. Out-of-Network \$5 copay for each Medicare covered diagnostic procedure, test and/or lab service.	In-Network <i>\$0 to \$5 copay for each Medicare covered diagnostic procedure, test and/or lab service. Low cost lab services, such as a routine hemoglobin glycated (HbA1c) test, are performed at a \$0 copay, while most lab services will fall under the \$5 copay.</i> Out-of-Network <i>\$0 to \$5 copay for each Medicare covered diagnostic procedure, test and/or lab service. Low cost lab services, such as a routine hemoglobin glycated (HbA1c) test, are performed at a \$0 copay, while most lab services will fall under the \$5 copay.</i>
Services to treat kidney disease	In-Network \$25 copay for each Medicare covered renal dialysis. Out-of-Network \$25 copay for each Medicare covered renal dialysis.	In-Network 20% of the cost for each Medicare covered renal dialysis. Out-of-Network 20% of the cost for each Medicare covered renal dialysis.

Cost	2018 (this year)	2019 (next year)
Skilled Nursing Facility	In-Network You pay a \$20 copay per day for days 1-20 of a Medicare covered SNF stay. You pay a \$167 copay per day for days 21-54 of a Medicare covered SNF stay. You pay a \$0 copay per day for days 55-100 of a Medicare covered SNF stay. Out-of-Network You pay a \$20 copay per day for days 1-20 of a Medicare covered SNF stay. You pay a \$167 copay per day for days 21-54 of a Medicare covered SNF stay. You pay a \$0 copay per day for days 55-100 of a Medicare covered SNF stay.	In-Network You pay a \$20 copay per day for days 1-20 of a Medicare covered SNF stay. You pay a \$172 copay per day for days 21-54 of a Medicare covered SNF stay. You pay a \$0 copay per day for days 55-100 of a Medicare covered SNF stay. Out-of-Network You pay a \$20 copay per day for days 1-20 of a Medicare covered SNF stay. You pay a \$172 copay per day for days 21-54 of a Medicare covered SNF stay. You pay a \$0 copay per day for days 55-100 of a Medicare covered SNF stay.
Vision care	Routine eye examinations not covered in 2018.	In-Network <i>\$10 copay for each non-Medicare covered routine eye exam.</i> Out-of-Network <i>Reimbursement of up to a maximum of \$30 for each non-Medicare covered routine eye exam.</i>

SECTION 2 Administrative Changes

Cost	2018 (this year)	2019 (next year)
Covered diabetic testing supplies	\$10 copayment	<i>\$0 copayment</i>

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Network Platinum*Plus*

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2019.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2019 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- OR-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2019*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to <https://www.medicare.gov> and click “Find health & drug plans.” **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Network Health Insurance Corporation offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change to a different Medicare health plan, enroll in the new plan. You will automatically be disenrolled from Network Platinum*Plus*.
 - To change to Original Medicare with a prescription drug plan, enroll in the new drug plan. You will automatically be disenrolled from Network Platinum*Plus*.
- To change to Original Medicare without a prescription drug plan, you must either:
 - Send us a written request to disenroll. Contact customer service if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
 - – or – Contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2019.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get “Extra Help” paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area, may be allowed to make a change at other times of the year. For more information, see Chapter 8, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2019, and don’t like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2019. For more information, see Chapter 8, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Wisconsin, the SHIP is called The Board on Aging and Long Term Care.

The Board on Aging and Long Term Care is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. The Board on Aging and Long Term Care counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call The Board on Aging and Long Term Care at 800-242-1060. You can learn more about The Board on Aging and Long Term Care by visiting their website (longtermcare.wi.gov).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **“Extra Help” from Medicare.** People with limited incomes may qualify for “Extra Help” to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don’t even know it. To see if you qualify, call:
 - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
 - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
 - Your State Medicaid Office (applications).
- **Help from your state’s pharmaceutical assistance program.** Wisconsin has a program called Wisconsin Senior Care that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 5 of this booklet).

- **What if you have coverage from an AIDS Drug Assistance Program (ADAP)?** The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance. Contact the Wisconsin AIDS/HIV Drug Assistance Program at 608-267-6875 or 800-991-5532. Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.
- If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. The Wisconsin AIDS/HIV Drug Assistance Program can be reached at 608-267-6875 or 800-991-5532.
- For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Wisconsin AIDS/HIV Drug Assistance Program (ADAP) at 608-267-6875 or 800-991-5532.

SECTION 7 Questions?

Section 7.1 – Getting Help from Network Platinum*Plus*

Questions? We're here to help. Please call customer service at 800-378-5234. (TTY only, call 800-947-3529.) We are available for phone calls Monday through Friday, 8 a.m. to 8 p.m. Calls to these numbers are free.

Read your 2019 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2019. For details, look in the 2019 *Evidence of Coverage* for Network Platinum*Plus*. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is included in this envelope.

Visit our Website

You can also visit our website at networkhealth.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (<https://www.medicare.gov>). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to <https://www.medicare.gov> and click on “Find health & drug plans.”)

Read *Medicare & You 2019*

You can read *Medicare & You 2019* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (<https://www.medicare.gov>) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.